

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

10086
Reg. Dist. No. 2.02

1. PLACE OF DEATH:

County..... **Kent**
 City or town..... **Chestertown**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **life**
 Hospital, institution, or street address where death occurred:
334 Cannon St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County..... **Kent**
 City or town..... **Chestertown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **334 Cannon St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Annie Allen

3. (b) Social Security Number

4. Sex..... **female** 5. Color or race..... **colored** 6. (a) Single, married, widowed, or divorced..... **widowed**
 6. (b) Name of husband or wife..... **Noah Allen**
 7. Birth date of deceased (mo., day, yr.)..... **Sept. 29, 1902** 8. (c) If alive, give age..... years
 8. AGE: Years..... **44** Months..... **0** Days..... **26** If less than one day..... hrs. min.

9. Birthplace..... **Kent Co., Maryland**
 (Town, county, and state)
 10. Usual occupation..... **housewife**
 11. Industry or business.....

12. Name..... **Israel Thomas**
 13. Birthplace..... **Maryland**
 14. Maiden name..... **Martha Cephas**
 15. Birthplace..... **Maryland**

16. Informant..... **George Thomas (brother)**
 Address..... **Chestertown, Maryland**

17. Burial..... **Burial** Date thereof..... **Oct. 28, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Quaker Neck (Colored) Cem.**
 Location..... **Chestertown, Md.**

18. Funeral director..... **J. Willis Wells**
 Address..... **Chestertown, Maryland**

19. **Oct. 28, 46** **Clara S. Barnes**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Oct. 25** 19.. **46** at **6 A.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 19.. **46** to **Oct. 25** 19.. **46**
 and that I last saw him/her alive on **Oct. 21** 19.. **46**

Immediate cause of death..... **cardiac failure**
anasarca

Due to..... **arteriosclerotic and**
hypertensive cardiovascular diseases

Due to.....

Other conditions..... **malnutrition, emaciation,**
vitamin deficiency
 (Include pregnancy within 3 months of death)

Major findings of operations..... **none**
 Date of op.

Anteapay results..... **none**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **A. R. Compton** M. D. or other
 Address..... **Chestertown, Md.** Date signed..... **10-28-46**

RECEIVED
OCT 30 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

2010

1. PLACE OF DEATH:

County Kent
 City or town Chester town, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
Kent + Queen Anne guard hospital
 How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Worton, Chester town Md Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Colemans Rural Worton Md.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Rosie Brown

3. (b) Social Security Number

4. Sex 7 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Vincent Brown
 7. Birth date of deceased (mo., day, yr.) Oct 27, 1891 6. (c) If alive, give age 66 years
 8. AGE: Years 55 Months 11 Days 24 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 19 46 at 0015 M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 19 46 to Oct 22 19 46
 and that I last saw him alive on Oct 23, 1946 19 _____

Immediate cause of death

Pulmonary edema

DURATION

1 1/2 hours
3 yearsDue to arterial hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace Kent county, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name George Houston
 13. Birthplace Kent county, Md.
 14. Maiden name Enia
 15. Birthplace _____

16. Informant Vincent Brown
 Address Worton, Md. R.F.D.
 17. Colerick Date thereof Oct 27, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Colemans
 Location Rural Worton Md.
 18. Funeral director B. R. Willows
 Address Still Pond Md.
 19. Oct 26 19 46
 (Date rec'd by registrar)

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert W. Farr

M. D. or other

Address Chester town, Md. Date signed Oct 22, 1946

Registrar

2-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 3020

1. PLACE OF DEATH:

County Kent
 City or town Worton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs.
 Hospital, institution, or street address where death occurred:
Near 1.4 Church Worton Ind
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Worton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Worton
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Carrie B. Davies

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Alfred H. Davies

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1870 8.(c) If alive, give age 77 years

8. AGE: Years 75 Months 11 Days 25 If less than one day
 hrs. min.

9. Birthplace Baltimore County, Maryland
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Home12. Name Widow Christian Schmitt13. Birthplace Germany14. Maiden name Anna Fleck15. Birthplace Germany16. Informant Mrs. Alfred H. Davies (Widow)Address Worton, Maryland

17. Burial Date thereof 10/26/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. John's CemeteryLocation Long Green, Balto. Co., Ind.18. Funeral director Marion V. WilliamsAddress Chesapeake, Maryland19. Oct. 24, 1946 Class S. Barnes

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 19 46, at 2:15 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 19 44 to Oct. 24 19 46and that I last saw him alive on Oct. 24 19 46

Immediate cause of death

Arterio sclerosis

Due to

Myocardial infarction

Due to

Other conditions Arterio sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W. Smith M. D. or otherAddress Chesapeake Date signed Oct 24/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF BOSTON

DEATH OF

RECEIVED
OCT 26 1945
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

Reg. Dist. No. 10089 2010

1. PLACE OF DEATH:

County Kent County
 City or town Still Pond, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Still Pond
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Harry Davis Hendrickson

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Jessie Crew
 7. Birth date of deceased (mo., day, yr.) February 6, 1877
 8. AGE: Years 69 Months 8 Days _____ If less than one day _____ hrs. _____ min. _____
 6.(c) If alive, give age 61 years

9. Birthplace Kent County, Md.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business _____

FATHER 12. Name Augustine Hendrickson
 13. Birthplace Alleghenware
 MOTHER 14. Maiden name Mathilda Davis
 15. Birthplace Alleghenware

16. Informant Mrs. Jessie Hendrickson
 Address Still Pond, Md.

17. Burial Date thereof Oct 4 / 46
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory Still Pond md
 Location Still Pond md

18. Funeral director B. R. Gellows
 Address Still Pond md

19. Oct 5 19 46 J M Black
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 19 46 at 7:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to Oct. 4 19 46
 and that I last saw him alive on October 4 19 46

Immediate cause of death Cirrhosis of the liver
 DURATION 1945

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. Smith
 M. D. or other _____

Address Chesapeake Date signed Oct 4 / 46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2-35

RECEIVED
JULY 5 1946
BOSTON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

16090
Reg. Dist. No. 203

1. PLACE OF DEATH:

County... Kent
 City or town... Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 5 weeks
 Hospital, institution, or street address where death occurred:
Piney Creek
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Rock Hall Kent
 City or town... Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Piney Creek
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Nora Elizabeth Hignett

3. (b) Social Security Number

4. Sex... female 5. Color or race... Wh. 6. (a) Single, married, widowed, or divorced... widowed
 6. (b) Name of husband or wife... William A. Hignett
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... June 20 1888
 8. AGE: Years... 67 Months... 59 Days... 3 If less than one day... hrs. min. 20

9. Birthplace... Grasonville, Md.
(Town, county, and state)10. Usual occupation... House

11. Industry or business

FATHER 12. Name... Sam Dulin13. Birthplace... Marcus Hook Pa.MOTHER 14. Maiden name... Elizabeth Chance15. Birthplace... Grasonville, Md.16. Informant... Wm Ernest TrickettAddress... Rock Hall, Md.17. Burial Date thereof... Oct 14 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Centerville Md.Location... Centerville Md.18. Funeral director... Barton Bros.Address... Centerville Md.19. 10/14/46 19... S. Elwood Bmgose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct 10 19... 46 at... 8:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 2 19... 46 to... Oct 10 19... 46
 and that I last saw him/her alive on... Oct 10 19... 46

Immediate cause of death... Cancer of stomach
metastasis of liver
artery
 Due to...
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide...
 Date of...
 Where did injury occur?...
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)...
 Means of injury... Injured at work?

23. SIGNATURE... Amos A. Burzard M.D.
Rock Hall Md. M. D. or other
 Address... Date signed... 10/10/46

RECEIVED
OCT 14 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

Reg. Dist. No. 10091 2010

1. PLACE OF DEATH:

County... Kent

City or town... Kent
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ... 1 yr

Hospital, institution, or street address where death occurred:
... 20

How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent

City or town... Kennedyville RR
(If outside city or town limits, write RURAL and give nearest town)

Street No. ...

(If rural, give LOCATION)

2. (a) If veteran, name war ...

3. (a) FULL NAME

Edmond Sundall Hurst

3. (b) Social Security Number

4. Sex... Male

5. Color or race... white

6. (a) Single, married, widowed, or divorced... widowed

6. (b) Name of husband or wife... Sophia Scott

7. Birth date of deceased (mo., day, yr.)... September 11 - 1896

B. (c) If alive, give age... years

8. AGE: Years... 70 Months... 0 Days... 20 If less than one day... hrs. ... min.

9. Birthplace... Maryland Kent Co Md
(Town, county, and state)

10. Usual occupation... Farmer retired

11. Industry or business...

12. Name... James W. Hurst

13. Birthplace... Kent Co Md

14. Maiden name... Mary E. Woodland

15. Birthplace... Kent Co Md

16. Informant... Mrs. Samuel Hurst

Address... Kennedyville RR Md

17. Burial... Date thereof... Oct 4 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Shiloh

Location... Near Kennedyville Maryland

18. Funeral director... Martin Williams

Address... Chesterton Maryland

19. Oct 3 46 J. N. Blouck

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 1st 1946 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1944 to November 1944

and that I last saw him alive on October 23, 1945

Immediate cause of death...

DURATION

Circumstances of Death... 1945

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... James W. Hurst

Address... Chesterton Md

Date signed... Oct 2/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Signature of witness

11. Signature of funeral director

12. Signature of undertaker

13. Signature of coroner

14. Signature of justice of the peace

15. Signature of town clerk

16. Signature of selectmen

17. Signature of board of health

18. Signature of board of registration

19. Signature of board of probate

20. Signature of board of appeals

21. Signature of board of education

22. Signature of board of public safety

23. Signature of board of fire safety

24. Signature of board of fire prevention

25. Signature of board of fire insurance

26. Signature of board of fire protection

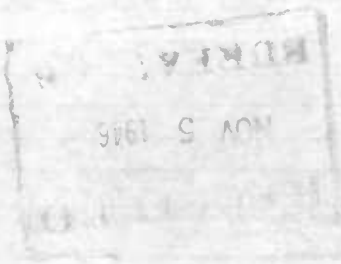
27. Signature of board of fire investigation

28. Signature of board of fire suppression

29. Signature of board of fire prevention and protection

30. Signature of board of fire prevention and protection

2-35



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

CERTIFICATE OF DEATH

10092 2020
Reg. Dist. No.

1. PLACE OF DEATH: 161st
County Chestertown
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10/28/46
Hospital, institution, or street address where death occurred: West 1st St. Home Hosp
How long in hospital or institution? 10/28/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County West
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME
Leon D. Hynson

3.(b) Social Security Number

4. Sex Male 5. Color or race Caucasian 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Esther D. Hynson

7. Birth date of deceased (mo., day, yr.) July 20, 1905 8.(c) If alive, give age 37 years

8. AGE: Years 41 Months 3 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace West 1st St. and
(Town, county, and state) Chestertown

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Charles Hynson

13. Birthplace Rock Hall, Md

14. Maiden name Myrtle D. Hynson

15. Birthplace West 1st St. and

16. Informant Myrtle D. Hynson (wife)

Address Wootton Md

17. Burial Date thereof Nov. 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bulletts

Location Bulletts - Kent Co. Maryland

18. Funeral director Margie V. Williams

Address Chestertown, Maryland

19. Nov. 3, 1946 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/46 19 46 at 8:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____
and that I signed the certificate of death on _____
Immediate cause of death Isaetion Cervical

Due to Veterine

Due to Isaetion Cervical

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. _____

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date on 10/28/46

Where did injury occur? Public Highway (City or town) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of injury Fell from Truck Injured at work? no

23. SIGNATURE Clara S. Barnes M. D. or other

Address Chestertown Md Date signed 10/30/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINTAIN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1-35

RECORDED
NOV 5 1946
H.M. 6018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10092
Reg. Dist. No. 2010

1. PLACE OF DEATH:

County Leopold
City or town Leopold
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Leopold
City or town Leopold
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Oliver P. Jarvis

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
B. (b) Name of husband or wife Elizabeth E. Jarvis
6. (c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Dec 9 1866
8. AGE: Years 85 Months 10 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Chester Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Relatable
12. Name Alfred Jarvis
13. Birthplace Maryland
14. Maiden name Elizabeth Scotten
15. Birthplace Maryland

16. Informant Mary Jarvis
Address Still Road md
17. Burial Date thereof Oct 23 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Chester
Location Chester town md

18. Funeral director B. P. Wellons
Address Still Road md
19. Oct 23 1946 J. H. Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946 of 320 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct - 18 1946 to Oct 20 1946
and that I last saw him alive on Oct 20 1946
Immediate cause of death _____ DURATION
Chronic Nephritis 2 years
Due to _____
Chronic Dehydration 24 hrs.
Due to _____
Other conditions Urinary tract 2 days
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. Smith M. D. or other
Chester town Date signed 10/21/46
Address _____

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2-35

RECORDED
JAN 5 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

100942021
Reg. Dist. No.

1. PLACE OF DEATH:

County Kent
 City or town near Rock Castle, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? whole life
 Hospital, institution, or street address where death occurred: Broad Neck
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chestertown, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Broad Neck
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Frederic Reed Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Sarah E. Wilson
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Hutchinson 1867

8. AGE: Years 79 Months ? Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Broad Neck
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

12. Name John Burg Johnson

13. Birthplace Kent Co

14. Maiden name Annita Sheres

15. Birthplace Kent Co, Md

16. Informant Silvana Perry

Address Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct. 19, 1946
 (month) (day) (year)

Cemetery or crematory Broad Neck

Location Broad Neck

18. Funeral director Asbury H. Perry

Address Chestertown, Md

19. Oct 18 1946 Clara S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2, 1946, to Oct 3, 1946.

and that I last saw him alive on Sept 3, 1946.

Immediate cause of death _____ DURATION _____

Cerebral Sclerosis 2 years

Due to _____

Due to Cerebral Sclerosis 7 years

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. Smith M. D. or other _____

Address Chestertown Date signed 10/17/46

MASSACHUSETTS STATE DEPARTMENT

DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT

RECEIVED

OCT 21 1946

BUREAU 68

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-B

CERTIFICATE OF DEATH

★ 10095 200
Reg. Dist. No.

1. PLACE OF DEATH:

County Kent
City or town Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life
Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

3. (a) FULL NAME

Maurice Catherine Jones

4. Sex Female 5. Color or race col. 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Noah Eliska Jones7. Birth date of deceased (mo., day, year) August 12, 18878. AGE: 59 years 1 month 20 days If less than one day — hrs. — min.9. Birthplace Kent Co. Md.
(Town, county, and state)10. Usual occupation House work11. Industry or business Home12. Name Blessyuan Wank13. Birthplace Ind.14. Maiden name Susan Saunders15. Birthplace Kent Co. Md.16. Informant Eraser JonesAddress Millington Md.17. Burial Date thereof Oct. 6, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Bethel CemeteryLocation Delto. Md.18. Funeral director Edward FellowsAddress Millington Md.19. Oct. 5 19 46 Edward Fellows
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Kent County MillingtonCity or town Millington
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1946 at 10:15 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from his last attackand that last saw him onday of med. exam. durationCarcinomaof prostateDue to metastasisDue to to spineOther conditions Syphilis

(Include pregnancy within 8 months of death)

Major findings of operation MalignedDate of op. Apr. 1946Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of noWhere did injury occur? no
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) noMeans of injury no Injured at work? no23. Signature of physician Frank James M.D.Date signed Oct 3, 1946

RECEIVED

OCT 11 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

10096

Reg. Dist. No. 20.2

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Kent
 City or town Fairlee
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

William T. K. Legg

3. (b) Social Security Number

220-12-1343

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Blanche Squires Legg
living 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 6, 1902
 8. AGE: Years 43 Months II Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Kent Co. Maryland
 (Town, county, and state)
 10. Usual occupation Farm Bureau
 11. Industry or business _____

FATHER 12. Name Harry H. Legg
 13. Birthplace Maryland
 MOTHER 14. Maiden name Estella Sparks
 15. Birthplace Maryland

16. Informant Mrs. Estella Legg (Mother)
 Address Chestertown, Md.

17. Burial Date thereof Oct. 15, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Chester Cem.
 Location Chestertown, Maryland

18. Funeral director J. Willis Wells
 Address Chestertown, Md.

19. Oct. 14 1946 Clara L. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1946 at 11 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____
 and that death was caused by _____
 Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none
 Date of op. _____
 Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Frank Hayes MD
Physician M. D. or other _____
 Address Chestertown Md Date signed Oct 14/46

RECEIVED

OCT 17 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10097202
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Kent

City or town..... Chestertown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chestertown Rural
(If outside city or town limits, write RURAL and give nearest town)Street No..... Locust Bottom
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

James Walton Middleton

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Isabelle M.

7. Birth date of deceased (mo., day, yr.)

May 7 1866

6. (c) If alive, give age..... years

8. AGE:

Years

80

Months

4

Days

27

If less than one day

..... hrs. min.

9. Birthplace.....

Kent Co., Md.
(Town, county, and state)

10. Usual occupation.....

retired

11. Industry or business.....

Farming

FATHER

12. Name.....

James W. Middleton

13. Birthplace.....

Kent Co., Md.

MOTHER

14. Maiden name.....

Parag L. Howard

15. Birthplace.....

Kent Co., Md.

16. Informant.....

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

Oct 7 1946
(month) (day) (year)

Cemetery or crematory.....

St. Pauls

Location.....

Chestertown, Md.

18. Funeral director.....

Elders L. Lane

Address.....

Church Hill Md.

19.

(Date rec'd by registrar)

Oct. 7 1946

Claus S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 4 1946 at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4:00

1946

to

Oct 4

1946

and that I last saw him..... alive on..... Oct 3 1946

Immediate cause of death.....

chronic Bronchitis

DURATION

Due to.....

chronic lung hypoxemia

Due to.....

decompensation

old age

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Albert A. Burgard M.D.

M.D. or other

Address.....

Rock Hall, Md.

Date signed..... 10/14/46

RECEIVED
OCT 9 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10098
 Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chesler P.O. #3
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:
Near Radehy's Bridge
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chesler
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Radehy's Bridge
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William Henry Kudler

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife Emma S. Kudler

7. Birth date of deceased (mo., day, yr.) January 19, 1871
 6.(c) If alive, give age 74 years

8. AGE: Years 75 Months 8 Days 16 It less than one day _____ hrs. _____ min.

9. Birthplace Chesler, Kent Co. Maryland
 (Town, County, and state)

10. Usual occupation Blacksmith - Retired

11. Industry or business

12. Name Henry Clay Kudler13. Birthplace Sharon14. Maiden name Sara S. Vernon15. Birthplace Kent Co. Maryland16. Informant Mrs. Emma S. KudlerAddress Chesler, Maryland

17. Burial Date thereof Oct. 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CheslerLocation Chesler, Maryland18. Funeral director Marion V. WilliamsAddress Chesler, Maryland

19. Oct. 8 19 46 Clara S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 19 46, at 4:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46 to Oct 5 19 46and that I last saw him alive on Oct 5 19 46Immediate cause of death Coronary

DURATION

2 daysDue to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. G. Simpson M. D. or otherAddress Chesler Date signed 10-6-46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
OCT 10 1946
BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-0

CERTIFICATE OF DEATH

10099
★ Reg. Dist. No. 202

1. PLACE OF DEATH:

County Alamshouse Kent Co.
 City or town Chestertown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Franklin
 City or town Franklin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10099
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John W. Reed

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80

hrs.

min.

9. Birthplace

Worton, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

unknown

15. Birthplace

16. Informant

Bryan Sutton (Supt.)

Address

Chestertown, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Oct. 14 - 1946
(month) (day) (year)

Cemetery or crematory

Alamshouse

Location

Chestertown - Rural

18. Funeral director

J. B. Sutton Supt.

Address

6 Chestertown

19.

(Date rec'd by registrar)

19 46Clara S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 1319 46at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 -19 40

to

Oct. 1319 46

and that I last saw him alive on

Oct. 1119 46

Immediate cause of death

Chs. Myocarditis

DURATION

Several

Due to

Chs. Intestinal Myelitis1926

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Mumtaz

M. D. or other

Address

Wilmington, Md.

Date signed

Oct. 13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 17 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10100

2010

1. PLACE OF DEATH:

County.....Kent
 City or town.....Still Pond md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....60 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Quarford County.....Kent
 City or town.....Still Pond md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas Spencer Silcox

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....married
 6.(b) Name of husband or wife.....Helen May Silcox
 7. Birth date of deceased (mo., day, yr.).....April 23 1883
 8. AGE: Years.....63 Months.....6 Days.....5 If less than one day..... hrs. min.

9. Birthplace.....Kent Co
 (Town, county, and state)
 10. Usual occupation.....Farmer
 11. Industry or business.....Farming
 12. Name.....John A. Silcox
 13. Birthplace.....Glennware
 14. Maiden name.....Sarah Innon
 15. Birthplace.....Kent Co md

16. Informant.....Charles Price
 Address.....Betterton md
 17. (Burial, cremation, or removal, Which?).....Burial Date thereof.....Oct 30 1946
 (month) (day) (year)
 Cemetery or crematory.....Londontown
 Location.....Baltimore md
 18. Funeral director.....B. P. Fellows
 Address.....Still Pond md
 19. (Date rec'd by registrar).....Oct 30 46 Registrar.....J. M. Clark

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct 28 1946 at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 26 1946 to Oct 28 1946
 and that I last saw him alive on Oct 28 1946

Immediate cause of death.....Angina Pectoris

Due to.....Arterial Sclerosis

Other conditions.....Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Major findings of operations.....none
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....none Date of.....
 Where did injury occur?.....none
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury.....none Injured at work?

23. SIGNATURE.....L. P. Atwell M. D. or other
 Address.....Still Pond md Date signed.....10-29-46

2-35

RECEIVED
NOV 5 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 834

CERTIFICATE OF DEATH

Reg. Dist. No. 202

10101

1. PLACE OF DEATH: **Kent**
 County.....
 City or town..... **Chester town**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **life**
 Hospital, institution, or street address where death occurred:
Maple Ave
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md.**..... County..... **Kent**
 City or town..... **Chester town**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **Maple Ave**
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

H. Stockton Startt

3. (b) Social Security Number

4. Sex..... **male**
 5. Color or race..... **white**
 6. (a) Single, married, widowed, or divorced..... **married**

6. (b) Name of husband or wife..... **Ada Startt**
 6. (c) If alive, give age..... **71**..... years

7. Birth date of deceased (mo., day, yr.)..... **Sept. 17, 1873**

8. AGE: Years..... **73** Months..... **I** Days..... **10** If less than one day..... hrs. min.

9. Birthplace..... **Kent Co., Maryland**
 (Town, county, and state)

10. Usual occupation..... **Farm Manager**

11. Industry or business.....

12. Name..... **Solomon Startt**

13. Birthplace..... **Maryland**

14. Maiden name..... **Louisa Cohee**

15. Birthplace..... **Maryland**

16. Informant..... **Mrs. Ada Startt**

Address..... **Chester town, Md.**

17. Burial..... **Burial** Date thereof..... **Oct. 29, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Chester Cem.**

Location..... **Chester town, Md.**

18. Funeral director..... **J. Willis Wells**

Address..... **Chester town, Md.**

19. **Oct 28**..... **1946**..... **Clara L. Barnes**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 27**..... 19**46** at..... **2 P.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 24..... 19**46** to..... **Oct 27**..... 19**46**
 and that I last saw him alive on..... **Oct 27**..... 19**46**

Immediate cause of death.....

Uremia

Due to.....

Hemiplegia.

Due to.....

Arteriosclerosis

Other conditions.....

Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Laurel Smith

Address..... **Chester town**..... Date signed..... **Oct 27/46**

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
OCT 30 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-E)

CERTIFICATE OF DEATH

10192
Reg. Dist. No. 202

1. PLACE OF DEATH: **KENT**
County.....
City or town..... **CHESTERTOWN**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **3 hrs.**
Hospital, institution, or street address where death occurred:
KENT & QUEEN ANNE CO. HOSPITAL
How long in hospital or institution? **2 hrs.**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **MD** County..... **KENT**
City or town..... **ROCK HALL**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... **W. W. II**

3. (a) FULL NAME **John T. Thompson**

3. (b) Social Security Number
220-01-0745

4. Sex **MALE** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **Separated**

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **Aug 28 1920** 6. (c) If alive, give age..... years

8. AGE: Years **26** Months **2** Days **0** If less than one day..... hrs. min.

9. Birthplace..... **ROCK HALL Md.**
(Town, county, and state)

10. Usual occupation..... **Waterman**

11. Industry or business.....

FATHER 12. Name..... **JAMES A. THOMPSON**

13. Birthplace..... **Kent Co. Md.**

MOTHER 14. Maiden name..... **MARGARET E. HILMAN**

15. Birthplace..... **Maryland**

16. Informant..... **JAMES A. THOMPSON**

Address..... **ROCK HALL, Md.**

17. Burial (Burial, cremation, or removal. Which?) **Burial** Date thereof..... **Oct. 31, 1946**
(month) (day) (year)

Cemetery or crematory..... **Wesley Chapel Cem.**

Location..... **Rock Hall, Md.**

18. Funeral director..... **J. Willis Wells**

Address..... **CHESTERTOWN, Md.**

19. **Oct. 31, 1946** **Clara J. Barnes**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Oct 28** 19 **46** at **2:07 A.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Oct 26** 19 **46** to **Oct 28** 19 **46** and that I last saw him alive on **10-28** 19 **46**

Immediate cause of death..... **Lobar Pneumonia**
Myocarditis

Due to.....

Due to.....

Other conditions..... **Toxic gastritis**
(B.M.R. 763)
(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... **Albert A. Burgard M.D.**
Rock Hall, Md. M. D. or other

Address..... **Rock Hall, Md.** Date signed **10/30/46**

Bray Miller
STAGT

RECEIVED
NOV 2 1946
BUREAU